RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: USMC

CASE NUMBER: PD0900047 BOARD DATE: 20100407

SEPARATION DATE: 20060810

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SUMMARY OF CASE: This covered individual (CI) was a Staff Sergeant/Counter Intelligence Specialist medically separated from the Marine Corps in 2006 after more than 10 years of service. The medical basis for the separation was Lumbago. The CI was referred to the Physical Evaluation Board (PEB), found unfit for continued military service, and separated at 20% disability using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Naval and Department of Defense regulations.

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CI CONTENTION: The CI states: “The board missed the fact that there were two other disks that were damaged due to the injury. I am requesting the PDBR look into this matter for accuracy and possible clarification if at all.”

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RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Service PEB | | | | VA (3 months Pre-Separation) | | | | |
| Condition | Code | Rating | Date | Condition | Code | Rating | Exam | Effective |
| Lumbago | 5242-5243 | 20% | 20060713 | Low Back Musculotendinous Strain Secondary to Rupture of L5-S1 Disk with Sciatica on Left with Residual Surgical Scar | 5237 | 20% | 20060515 | 20060811 |
| Lumbar Disk Degeneration | Cat 2 | Conditions that contribute to the unfitting condition(s) | |
| Lumbar Disk Herniation, Status Post Surgery | Cat 2 |
| Lumbar Radiculopathy | Cat 2 | Radiculopathy, Left Lower Extremity Associated with Low Back Musculotendinous Strain Secondary to  Rupture of L5-S1 Disk with Sciatica on Left with Residual Surgical Scar | 5237-8520 | 10% | 20060515 | 20060811 |
|  | Not in DES | | | Gastroesophageal Reflux Disease (GERD) | 7399-7346 | 0% | 20060515 | 20060811 |
|  | Not in DES | | | Tinnitus | 6260 | 10% | 20060515 | 20060811 |
| TOTAL Combined: 20% | | | | TOTAL Combined (*Includes Non-PEB Conditions*): 40% | | | | |

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ANALYSIS SUMMARY:

The CI has had back issues intermittently since 1997 when he jumped out of a helicopter. He had several years of low back pain and occasional left leg radiculopathy that continued to increase in severity. In December 2005, he had exacerbation of his symptoms and was unable to do his activities of daily living, including ambulation. He was loading his vehicle for the drive back to Djibouti when his back gave out. The CI felt the pain shoot down his left leg followed by numbness. He had severe pain radiating down the posterior aspect of his left thigh and posterior calf. This occurred while he was deployed in Africa; he was eventually MEDEVACed after Magnetic Resonance Imaging (MRI) was performed, and was not able to return to his active duty status. His symptoms continued to increase and his symptoms were not improved with activity modification, including physical therapy.

Clinical examination as well as radiographic examination at that time revealed lumbar disk degeneration at L5-S1 along with a large left paracentral disk herniation. MRI confirmed this, revealing a large left paracentral disk at L5-Sl. His clinical examination at that time was significant for decreased motor strength graded at 4/5 in the L5 dermatomal distribution. The remainder of his lower extremities were graded as a 5/5. He had a positive straight leg raise and a positive contralateral straight leg raise. He had normal reflexes and normal bowel and bladder function.

Treatment options were discussed with him to include nonoperative and operative intervention. The patient eventually underwent operative intervention with a lumbar decompression and diskectomy surgery. This was performed on 01/17/2006. After surgery, the CI continued to have symptoms and an MRI documented protrusion of L1-L2, L2-L3 disks as well as L5-S1 disk bulge.

Prior to surgery motor strength was 4/5 in L5 distribution, but after surgery it was 5/5 throughout. Reflexes were normal before and after surgery. Straight leg raise was positive prior to surgery but result after surgery was not documented in the NARSUM. Sensation prior to surgery was not documented in the NARSUM, but after surgery sensation to light touch was decreased in the L5 dermatomal distribution of the left leg. Range of motion (ROM) measurements are in the chart below.

(Separation 20060810)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Movement  Thoracolumbar | Normal ROM | ROM Mil  20050522 | ROM VA  20060515 | ROM Mil  20050302 |
| Flex | 0-90 | 30-50 | 0-50 (pain) | restricted 25% |
| Ext | 0-30 | 10 | 0-30 | restricted 25% |
| R Lat flex | 0-30 | 10 | 0-30 | Full lateral flexion |
| L lat flex | 0-30 | 10 | 0-30 | Full lateral flexion |
| R rotation | 0-30 | 10 | 0-30 |  |
| L rotation | 0-30 | 10 | 0-30 |  |
| COMBINED | 240 | 80-100 | 200 |  |
| Notes: |  | Motor strength of both lower extremities is 5/5.  Deep tendon reflexes are 2+. Sensation to light touch is decreased in the L5 dermatomal distribution of the left leg. The remainder of his light touch sensation is intact. | Positive muscle spasm with abnormal spinal contour.  Positive straight leg raise.  Decreased sensation lateral left leg, calf, and foot. No motor loss. |  |

The CI did have herniated disks at multiple levels and repair of one level.

At the time of separation he continued to have some mild low back pain as well as intermittent lumbar radiculopathy. His symptoms were exacerbated by high impact exercises, carrying heavy loads, climbing, bending, twisting, and torquing. There was no improvement despite a high level of motivation and an intensive rehabilitative program.

The CI had another compensation and pension exam done in 2008 but no Veterans Administration Rating Decision (VARD) is available for this evaluation. This evaluation showed thoracolumbar flexion limited to 70 degrees with pain at 20 degrees. This appears to be a worsening over time, not an erroneous exam in 2006.

Radiculopathy:

The CI did have radiating pain and postural abnormalities with decreased feeling on the lateral part of the left leg down onto the left calf, and on top of the left foot. It was mostly a slight sensory loss with no loss of motor function. However, this condition does not appear to have affected the CI’s ability to perform his required tasks and there are no duty restrictions attributable to this condition. Radiating Pain is included in the overall spine rating.

Other Conditions Not in the Disability Evaluation System (DES):

Gastroesophageal Reflux Disease (GERD) and Tinnitus

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BOARD FINDINGS: IAW DoDI 6040.44, provisions of DoD or Military Department regulations or guidelines relied upon by the PEB will not be considered by the Board to the extent they were inconsistent with the VASRD in effect at the time of the adjudication. After careful consideration of all available information the Board unanimously determined that the CI’s condition is most appropriately rated as 20% for 5243 Intervertebral Disc Syndrome.

Spine conditions are rated using the VASRD General Rating Formula for Diseases and Injuries of the Spine. This formula is based on the limitation of range of motion (ROM) of the spine with or without symptoms such as pain (whether or not it radiates), stiffness, or aching in the area of the spine affected. While having multiple herniated disks could cause a greater limitation of ROM, having multiple herniated disks would not be cause for a higher rating unless there was, in fact, a greater limitation in the ROM. The CI’s back condition is rated at 20% based on thoracolumbar flexion limited to 50 degrees and a combined range of motion of less than 120 degrees that was present when he separated from service.

The Board also considered the condition of Radiculopathy, Left Lower Extremity and unanimously determined that this condition was not unfitting at the time of separation from service and therefore no rating is applied. While a radiculopathy was present at the time of separation as evidenced by decreased sensation in the L5 distribution, this condition did not interfere with satisfactory performance of any required duties. No duty restrictions or limitations are attributable to this condition.

The other diagnoses rated by the VA (Gastroesophageal Reflux Disease and Tinnitus) were not mentioned in the Disability Evaluation System (DES) package and are therefore outside the scope of the Board. The CI retains the right to request his service Board of Correction for Naval Records (BCNR) to consider adding these conditions as unfitting.

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RECOMMENDATION: The Board therefore recommends that there be no recharacterization of the CI’s disability and separation determination.

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090120, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

**DEPARTMENT OF THE NAVY**

SECRETARY OF THE NAVY COUNCIL OF REVIEW BOARDS  
 720 KENNON STREET SE STE 309  
 WASHINGTON NAVY YARD DC 20374-5023

IN REPLYREFER TO

1850 CORB:003 26 April 2010

From: Director, Secretary of the Navy Council of Review Boards

To:

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR)

Ref: (a) DoDI 6040.44

(b) PDBR ltr of 12 Apr 10

1. Pursuant to reference (a), the PDBR reviewed your case and forwarded its recommendation (reference (b)) to the Department of the Navy for appropriate action.

2. On 23 April 2010, the Assistant Secretary of the Navy (Manpower & Reserve Affairs) took action in your case by accepting the recommendation of the PDBR that no change be made to the characterization of separation or disability rating assigned by the Department of the Navy's Physical Evaluation Board.

3. The Secretary's decision represents final action in your case by the Department of the Navy and is not subject to appeal or further review by the Board for Correction of Naval Records.

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| Copy | to: |
| PDBR |